

ADULT INITIAL HISTORY AND PHYSICAL

Today's Date: ____ / ____ / ____ Age: ____ Family Doctor: ____ ☐ LEP: Interpreter ____

Please complete the following information:

What is the main reason for your visit today?			
Are you having any problems or symptoms today that you would like to discuss? <input type="checkbox"/> yes <input type="checkbox"/> no			
If you answered yes, please briefly explain:			
Are you allergic to any medicines or foods? <input type="checkbox"/> yes <input type="checkbox"/> no			
If you answered yes, please list what medicines or foods you are allergic to and your reaction to each:			
Current medications (<i>Prescription / Over the counter</i>): <input type="checkbox"/> None <input type="checkbox"/> Multivitamins <input type="checkbox"/> Calcium <input type="checkbox"/> Birth Control _____			
<input type="checkbox"/> Other:			
Have you had any hospitalizations, major injuries, or surgeries? <input type="checkbox"/> yes <input type="checkbox"/> no			
If you answered yes, please briefly explain:			
Living Conditions: <input type="checkbox"/> Alone <input type="checkbox"/> With family: # of children in home _____ <input type="checkbox"/> With Roommate <input type="checkbox"/> In group or foster home			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Education: <input type="checkbox"/> Not a student.		Employment: <input type="checkbox"/> Not employed	
Highest education level completed: _____		<input type="checkbox"/> Currently employed: Where? _____	
<input type="checkbox"/> Current Student: School _____		Grade _____	
Please check if you have or have had any of the following: <input type="checkbox"/> NO CURRENT COMPLAINTS			
CONSTITUTIONAL <input type="checkbox"/> Fatigue <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Fever/chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Recent weight change	HEAD, FACE, NECK <input type="checkbox"/> Headaches <input type="checkbox"/> Reduced facial strength <input type="checkbox"/> Recent hair loss <input type="checkbox"/> Scalp tenderness <input type="checkbox"/> Swollen glands in the neck	CARDIOVASCULAR <input type="checkbox"/> Angina or heart attack <input type="checkbox"/> Chest pain or pressure <input type="checkbox"/> Fast or irregular heart beat <input type="checkbox"/> Swelling of feet / ankles <input type="checkbox"/> Poor circulation <input type="checkbox"/> Blood clots <input type="checkbox"/> High blood pressure	RESPIRATORY <input type="checkbox"/> Asthma or Wheezing <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Cough with mucous production <input type="checkbox"/> Chronic or frequent coughs <input type="checkbox"/> Dry cough <input type="checkbox"/> Pain on breathing <input type="checkbox"/> Spitting/coughing blood
EYES <input type="checkbox"/> Blurred or double vision <input type="checkbox"/> Dryness / Redness <input type="checkbox"/> Wear glasses or contacts <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma	CHEST/BREAST <input type="checkbox"/> Breast discharge <input type="checkbox"/> Breast lump <input type="checkbox"/> Breast pain <input type="checkbox"/> Breast implants	GENITOURINARY <input type="checkbox"/> Burning or painful urination <input type="checkbox"/> Blood or pus in urine <input type="checkbox"/> Incontinence or dribbling <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Irregular periods <input type="checkbox"/> Painful periods <input type="checkbox"/> Prostate problems <input type="checkbox"/> Testicular pain <input type="checkbox"/> Sexual difficulty <input type="checkbox"/> Genital rash or ulcers	MUSCULOSKELETAL <input type="checkbox"/> Back pain <input type="checkbox"/> Cold extremities <input type="checkbox"/> Numbness or tingling <input type="checkbox"/> Paralysis <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint stiffness or swelling <input type="checkbox"/> Weakness of muscles or joints <input type="checkbox"/> Walk with assistive device <input type="checkbox"/> Difficulty climbing stairs
EARS/NOSE/MOUTH/THROAT <input type="checkbox"/> Earaches or drainage <input type="checkbox"/> Ringing in the ears <input type="checkbox"/> Hearing loss <input type="checkbox"/> Sinus infections/problems <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Frequent sore throat <input type="checkbox"/> Dryness of the mouth <input type="checkbox"/> Bad breath/bad taste <input type="checkbox"/> Mouth sores/ulcers <input type="checkbox"/> Voice changes <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Dentures	GASTROINTESTINAL <input type="checkbox"/> Heartburn or indigestion <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Changes in bowel habits <input type="checkbox"/> Painful bowel movements <input type="checkbox"/> Constipation <input type="checkbox"/> Frequent diarrhea <input type="checkbox"/> Hemorrhoids/blood in stool <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Abnormal liver tests/ liver disease	SKIN <input type="checkbox"/> Rash or itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Change in skin color <input type="checkbox"/> Psoriasis <input type="checkbox"/> Skin nodules or bumps <input type="checkbox"/> Easy bruising <input type="checkbox"/> Sores that won't heal	NEUROLOGICAL / PSYCHIATRIC <input type="checkbox"/> Convulsions or seizures <input type="checkbox"/> Tremors <input type="checkbox"/> Memory loss or confusion <input type="checkbox"/> Light headed/ Dizziness <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Stroke <input type="checkbox"/> Depression
ENDOCRINE <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Change in tolerance to hot/cold weather			

Please ✓ those that apply to you or your blood relatives.

Father

Brother

Grandparent

Child

HIV/AIDS							
Alcohol / Drug Addiction							
Alzheimer's							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder / Free Bleeder							
Cancer							
COPD / Emphysema / Chronic Bronchitis							
Diabetes							
Epilepsy / Convulsions / Seizures							
Heart Attack / Stroke							
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Liver Disease / Hepatitis							
Mental Illness / Depression							
Osteoporosis							
Sickle Cell							
Thyroid Disorder							
Tuberculosis/TB							
Other:							

Nutrition: check foods you eat every day <input type="checkbox"/> Milk / Dairy <input type="checkbox"/> Meats <input type="checkbox"/> Vegetables <input type="checkbox"/> Fruits <input type="checkbox"/> Breads or Grains		Do you have concerns about your weight? <input type="checkbox"/> Yes <input type="checkbox"/> No		Exercise <input type="checkbox"/> None <input type="checkbox"/> Seldom <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent	
Tobacco Use / Smoke Exposure <input type="checkbox"/> Never used <input type="checkbox"/> Exposed to smoke <input type="checkbox"/> Past user: type _____ <input type="checkbox"/> Use now: type _____ (# per day _____)		Alcohol <input type="checkbox"/> None <input type="checkbox"/> Seldom: type _____ <input type="checkbox"/> Occasional: type _____ <input type="checkbox"/> Frequent: type _____		Street Drugs <input type="checkbox"/> None <input type="checkbox"/> Seldom: type _____ <input type="checkbox"/> Occasional: type _____ <input type="checkbox"/> Frequent: type _____	
Dental Health <input type="checkbox"/> Brush daily <input type="checkbox"/> Floss daily <input type="checkbox"/> Visit dentist every 6 months		Water Source: <input type="checkbox"/> Well <input type="checkbox"/> Cistern <input type="checkbox"/> Bottled <input type="checkbox"/> City		Mental Health: (in past 90 days) <input type="checkbox"/> No Problem <input type="checkbox"/> Mild/Moderate Depression <input type="checkbox"/> Severe Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Thoughts of harming self / others	
Abuse / Neglect / Violence: <input type="checkbox"/> No fear of harm <input type="checkbox"/> Pressure to have sex <input type="checkbox"/> Daily needs not met <input type="checkbox"/> Forced sexual contact <input type="checkbox"/> Fear of verbal/physical abuse <input type="checkbox"/> Sex for money or drugs		Sexually Active with: <input type="checkbox"/> not sexually active <input type="checkbox"/> Males <input type="checkbox"/> Females <input type="checkbox"/> Both Number of partners: in past month _____ in past 2 months _____ in past 12 months _____		Travel: <input type="checkbox"/> No travel outside USA <input type="checkbox"/> Traveled outside USA: Country/Year _____ / _____	
Reproductive Life Plan: Do you have any children? <input type="checkbox"/> yes <input type="checkbox"/> no Do you want more children? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, how many more children do you want to have and when? _____ What type of birth control are you using to prevent pregnancy? _____ <input type="checkbox"/> none		Females only: Do you examine your breasts every month? <input type="checkbox"/> Yes <input type="checkbox"/> No First day of last menstrual period: ____ / ____ / ____			
Patient Signature: _____		Healthcare Provider Signature: _____		Date: _____	

TO BE COMPLETED BY HEALTHCARE PROVIDER			
FEMALES ONLY		MALES ONLY	
Age of menarche: # Days between periods: # Days of bleeding: Problems with menses: <input type="checkbox"/> yes <input type="checkbox"/> no Describe:		# living children: Fertility problems: <input type="checkbox"/> yes <input type="checkbox"/> no Describe:	
Age at first pregnancy: G Para SAB ETP # living children:		Hx of testicular biopsy: <input type="checkbox"/> yes <input type="checkbox"/> no Date / Year: Result:	
Hx of NTD: <input type="checkbox"/> yes <input type="checkbox"/> no Age at last pregnancy: Date of last delivery:		PSA testing: <input type="checkbox"/> yes <input type="checkbox"/> no Most recent date / year: Result:	
Fertility problems: <input type="checkbox"/> yes <input type="checkbox"/> no Describe:		Hx of abnl PSA: <input type="checkbox"/> yes <input type="checkbox"/> no Date / Year: Result:	
Currently using contraception: <input type="checkbox"/> yes <input type="checkbox"/> no Type:		Digital rectal exams: <input type="checkbox"/> yes <input type="checkbox"/> no Most recent date / year: Result:	
Interruption in B/C method? <input type="checkbox"/> yes <input type="checkbox"/> no Describe:		Hx of abnl digital rectal exam: <input type="checkbox"/> yes <input type="checkbox"/> no Date / Year: Result:	
Menopausal symptoms: <input type="checkbox"/> yes <input type="checkbox"/> no Describe:		Sigmoidoscopy: <input type="checkbox"/> yes <input type="checkbox"/> no Date / Year: Result:	
HRT: <input type="checkbox"/> yes <input type="checkbox"/> no Type:		FOBT: <input type="checkbox"/> yes <input type="checkbox"/> no Year: Result: <input type="checkbox"/> pos <input type="checkbox"/> neg	
Age at final menses: Rubella status: <input type="checkbox"/> immune <input type="checkbox"/> unknown		Colonoscopy: <input type="checkbox"/> yes <input type="checkbox"/> no Year: Result:	
DES Exposure: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown		SEXUAL HISTORY	
Routine Pap Tests: <input type="checkbox"/> yes <input type="checkbox"/> no Most recent date / Year: Result:		Sexual partners: <input type="checkbox"/> men <input type="checkbox"/> women <input type="checkbox"/> both	
Hx of abnl pap / HPV: <input type="checkbox"/> yes <input type="checkbox"/> no Date / Year: Result:		# Sexual partners: lifetime _____ last year _____ last 60 days _____ last 30 days _____	
Hx of colposcopy/biopsy: <input type="checkbox"/> yes <input type="checkbox"/> no Date / Year: Result:		Sex with anonymous partners: <input type="checkbox"/> yes <input type="checkbox"/> no	
Mother, sister, daughter with breast cancer < age 50? <input type="checkbox"/> yes <input type="checkbox"/> no		First sexual contact <18 yrs of age: <input type="checkbox"/> yes <input type="checkbox"/> no	
Currently breastfeeding: <input type="checkbox"/> yes <input type="checkbox"/> no Ever breastfed: <input type="checkbox"/> yes <input type="checkbox"/> no		Bleeding, spotting, pain with intercourse: <input type="checkbox"/> yes <input type="checkbox"/> no Describe:	
Routine Mammograms: <input type="checkbox"/> yes <input type="checkbox"/> no Most recent date / Year: Result:		Condoms used routinely: <input type="checkbox"/> yes <input type="checkbox"/> no	
Hx of abnl mammogram / CBE: <input type="checkbox"/> yes <input type="checkbox"/> no Date / Year: Result:		Hx of STDs: <input type="checkbox"/> yes <input type="checkbox"/> no Hx of ≥ 2 STDs: <input type="checkbox"/> yes <input type="checkbox"/> no Disease(s):	
Hx of breast biopsy: <input type="checkbox"/> yes <input type="checkbox"/> no Date / Year: Result:		HIV tested: <input type="checkbox"/> yes <input type="checkbox"/> no Most recent date: Result: <input type="checkbox"/> pos <input type="checkbox"/> neg Unprotected sex since last test: <input type="checkbox"/> yes <input type="checkbox"/> no	
FOBT: <input type="checkbox"/> yes <input type="checkbox"/> no Year: Result: <input type="checkbox"/> pos <input type="checkbox"/> neg Colonoscopy: <input type="checkbox"/> yes <input type="checkbox"/> no Year: Result:		Lead Assessment: Verbal Risk Assessment: <input type="checkbox"/> neg <input type="checkbox"/> pos <input type="checkbox"/> N/A Tested Today: <input type="checkbox"/> yes <input type="checkbox"/> no Referred for testing: <input type="checkbox"/> yes <input type="checkbox"/> no	
Immunization Status: <input type="checkbox"/> Up to date by patient report <input type="checkbox"/> Records Requested <input type="checkbox"/> See Vaccine Administration Record <input type="checkbox"/> Vaccines given today			
Preventive Health Education: <i>topics discussed today</i> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Child development <input type="checkbox"/> Immunizations <input type="checkbox"/> Dental <input type="checkbox"/> Hearing/Vision <input type="checkbox"/> Lead exposure (ACH-25a) <input type="checkbox"/> Diet / Nutrition <input type="checkbox"/> Physical activity </div> <div style="width: 50%;"> <input type="checkbox"/> Safety <input type="checkbox"/> Mental Health <input type="checkbox"/> DV/SA <input type="checkbox"/> ATOD / Cessation / SHS <input type="checkbox"/> Diabetes <input type="checkbox"/> CVD <input type="checkbox"/> Arthritis </div> <div style="width: 50%;"> <input type="checkbox"/> Preconception /Folic Acid <input type="checkbox"/> Prenatal / Genetics <input type="checkbox"/> SBE /Mammogram <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Cancer <input type="checkbox"/> STE / PSA </div> <div style="width: 50%;"> <input type="checkbox"/> Pelvic / Pap <input type="checkbox"/> HRT <input type="checkbox"/> STD / HIV/ HCV <input type="checkbox"/> Options Counseling <input type="checkbox"/> Reproductive Life Plan </div> </div>		Educational Handouts: <input type="checkbox"/> FPEM <input type="checkbox"/> PTEM <input type="checkbox"/> CSEM <input type="checkbox"/> Other:	
Minor Family Planning Counseling: <input type="checkbox"/> Abstinence <input type="checkbox"/> Sexual coercion <input type="checkbox"/> Benefits of parental involvement in choices			
Patient verbalizes understanding of education given <input type="checkbox"/>			
Healthcare Provider Signature:		Date:	

